MEETING SUMMARY

Advisory Committee to the Director (ACD)

Centers for Disease Control and Prevention (CDC)

8:30 AM – 2:00 PM

April 20, 2017

David W. Fleming, MD, MPH, ACD Chair

Sarah Wiley, Acting Chief of Staff and ACD Designated Federal Officer (DFO)

Welcome, Roll Call, and Introductions:
David Fleming opened up the meeting at 8:32 am. Sarah Wiley, Designated Federal Officer, called roll and asked that any conflicts of interested be identified; there were none. CDC staff and members of the public introduced themselves.

Director's Update & Discussion:
Acting CDC Director, Anne Schuchat, opened the discussion with an overview of CDC's mission: to prevent, detect, and respond to public health threats. She described CDC's work through six broad themes, providing examples of work in each of these areas: (1) communications and guidance, (2) epidemiology and surveillance, (3) global health, (4) innovation, (5) laboratory/diagnostics, and (6) support to state and local health departments. As an example of CDC's work in health communication, Dr. Schuchat highlighted the "Tips from Former Smokers" campaign, which is currently in its 5th year; she cited estimates that more than 500,000 smokers have quit as a result of "Tips." Dr. Schuchat went on to discuss CDC's monthly Vital Signs reports, in particular, the recent Zika Vital Signs, and accompanying Morbidity and Mortality Weekly Report (MMWR), which came out at the beginning of April. In the report, the Zika Emergency Response's Pregnancy and Birth Defects Task Force estimated that approximately 10 percent of Zika infections in pregnant women result in babies born with Zika-associated birth defects.

Next, Dr. Schuchat provided examples of CDC's work in epidemiology and surveillance, noting that Zika continues to be a concern, with over 5,000 cases in the Continental United States. Approximately two hundred of those cases come from local transmission in South Florida and around Brownsville, Texas. CDC's influenza program measured the efficacy of pediatric flu vaccines, finding that they reduced death by 65 percent. The HIV/AIDS program has seen a general decline in rates of infection from 2008 to 2014; however, there is a notable rise in infection among gay/bisexual men ages 25-44. Another recent publication in the New England Journal of Medicine has found that type 2 diabetes in children continues to rise, with very sharp rates in both the Native American and Non-Hispanic Black populations. Dr. Schuchat recapped some of the outbreaks that have occurred since the committee's last meeting: *E. coli* in soy nut butter, increased rates of mumps, and the Seoul virus in rats bred for snake owners. She also noted that as recently as last week, bat remains were detected in packaged salad.

In global health, Dr. Schuchat highlighted yellow fever outbreaks in South America and Africa, which have been alarming. Rural areas have had trouble managing the outbreak and its rapid spread has led to vaccine shortages. We continue to make progress toward the eradication of polio, but new cases in Nigeria in August 2016 have caused concern. Challenges to surveillance, resulting from security concerns in parts of Afghanistan, Pakistan, and Nigeria, have allowed the disease to circulate undetected. CDC continues to focus on containment. In addition to yellow fever and polio, a fifth wave of H7N9 avian flu virus was detected in China at the beginning of 2017. This is the largest wave yet and it has shown increased rates of mortality. Vaccines in CDC's stockpile are also less effective against this strain of H7N9. The most worrisome cases have occurred on the southern Chinese border with Vietnam where there is an extensive bird trade, placing the Vietnamese health authorities on alert.

Dr. Schuchat again highlighted the Morbidity and Mortality Weekly Report (MMWR), specifically those issues dedicated to rural health. She mentioned that Von Nguyen, Acting Associate Director for Policy would be giving a presentation on the topic later in the day, in addition to a discussion of the opioid epidemic, led by Debra Houry, Director of the National Center for Injury Prevention and Control.

Dr. Schuchat congratulated the foodborne illness team on its progress in scaling up genetic sequencing detection methods throughout the country since October 2015. In addition, CDC's Advanced Molecular Detection techniques identified four different strains of *Candida auris* circulating in four different regions of the world. It can persist on skin and on bed rails, with some strains resistant to all known anti-fungal classes of drugs. The Winnable Battles Initiative continues to move forward, though CDC is revising the process based on lessons learned in the past year.

The Secretary of Health and Human Services (HHS), Dr. Tom Price, visited the agency last month to meet with senior leaders and tour CDC facilities. Secretary Price noted that his key priorities for HHS are addressing the opioid epidemic, childhood obesity, and mental health. Secretary Price plans to represent the U.S. at the World Health Assembly in Geneva in May as well as at the G20 summit. His advance team has already visited CDC's offices in Liberia and Sierra Leone in preparation for a trip by the Secretary himself. Dr. Schuchat acknowledged the high degree of uncertainty regarding the transition, but affirmed that she would share information with the ACD as she receives it. During his visit, Secretary Price called CDC a "jewel of the nation" and said it was very special to have its headquarters in his hometown. A number of people have stepped into CDC leadership positions on an acting basis during the transition. Dr. Schuchat updated the committee on the current organizational chart and people in acting leadership roles.

CDC has faced some recent challenges related to aging facilities both in Georgia and in other states. For example, the high containment laboratory's building automation system is aging and is in need of repair; CDC has been conducting assessments to determine where to focus the resources necessary to make repairs and sustain our critical work. CDC also faces challenges in maintaining its workforce, which will continue to grow as a concern as more employees reach retirement age. Recruiting and retaining highly qualified personnel and cybersecurity professionals is a top priority for the agency's leaders.

Budgetary uncertainty also remains an issue of concern. It's unclear whether the Continuing Resolution that expires on April 28th will be extended and what that will mean for CDC. The President's "skinny budget" for FY 2018 did not provide specific details for CDC, but it did outline an 18 percent cut to HHS's overall budget. As a final note, Dr. Schuchat stated that one of her priorities throughout this process is engagement with all parts of CDC, to increase support for CDC's critical work and talented workforce.

Chair Opens Discussion on Current Issues:
Dileep Bal asked about the rumors, with regards to the budget, that there will be block grants. He asked the ACD to take a position on this issue, arguing that the current fiscal environment increases the temptation for states to redirect CDC funds.

In reference to the overview of the agency, Lynn Goldman wanted Dr. Schuchat to be sure to highlight just how innovative CDC's science is, because there's a general lack of knowledge about the scientific underpinnings of public health. Tom Farley and Jonathan Fielding expressed concurring opinions about this topic. Dr. Farley conveyed his views on the great impact CDC has because of its visibility around the country, and expressed hope that CDC will continue to provide its expert perspective and authority on public health matters. Dr. Fielding suggested Dr. Schuchat provide examples for each of the six themes outlined in her presentation, for illustrative effect. Lynne Richardson seconded Dr. Goldman's earlier point about strengthening the connection to science.

Chris Elias emphasized the need to protect CDC's work in global health, particularly in an austere budget environment. He argued that without demonstrating how each global program can be tied directly to the health of Americans, such initiatives may be easier to cut. Of still greater concern is the fate of innovative scientific projects, which are currently funded by supplements, whose financing may lapse in FY '19. Dr. Elias explained that many international agencies get things done with behind the scenes help from CDC, and he suggested highlighting this fact with another story to illustrate the importance of CDC's work.

Dr. Schuchat expressed appreciation for the feedback about her presentation and for the helpful input on how best to demonstrate the effectiveness of CDC's funding. She also acknowledged that while NIH leads the charge on research, CDC is responsible for a lot of scientific innovation. Dr. Schuchat highlighted work done by CDC's Fort Collins staff to develop the first DNA vaccine against West Nile virus (which is used in horses), providing the basis for vaccines currently under development to prevent Zika.

She also noted that the employee photo contest could be used to supply some of the illustrations of our work, as Dr. Fielding suggested. As a final note, Dr. Schuchat welcomed further feedback from ACD members about what the agency ought to be doing now.

Discussion on Opioid Overdose:
Debra Houry, Director of the National Center for Injury Prevention and Control (NCIPC), gave the presentation. CDC staff just returned from the 2017 National Rx Drug Abuse & Heroin Summit, which was the largest yet. NCIPC aims to have a comprehensive, continuous, and compassionate response to the opioid epidemic. The nation continues to face a rise in opioid deaths of all kinds, except methadone. Fentanyl and heroin are the primary drivers for this increase, which is present across the U.S., from the Southwest through Appalachia to the Northeast.

CDC's *Guideline for Prescribing Opioids for Chronic Pain* has been endorsed by 22 medical organizations, 18 states, and three insurance companies since its inception one year ago. Blue Cross/Blue Shield released a report supporting CDC's principles on opioid overdose prevention, while Cigna saw a decrease in prescribing opioids after implementing the guidelines. NCIPC offers continuing medical education (CME) credit through a seven part webinar on opioids that has been taken by 3000 people. Numerous nursing and medical schools have pledged to include the *Guideline* as part of their curricula. For each of the 12 guidelines, CDC developed corresponding quality measures, which are currently being

used to demonstrate their impact. States have also begun to incorporate prescription drug monitoring programs (PDMP) into electronic health records (EHR), with Ohio monitoring drug prescriptions in all Kroger pharmacies.

In terms of grants, NCIPC's FY '15 funds were increased in FY '16, so that the Center now funds programs in 44 states and Washington, D.C. Grant funds were allocated according to the severity of the epidemic and the capacity/readiness in that state. One primary prevention strategy has been improving PDMPs for ease of use and to increase proactive notifications. Primary prevention interventions and improving data timeliness have been the main focus of the program. CDC has also been providing technical assistance to help states create their own data-driven initiatives. At the beginning of FY '16, NCIPC received funding to implement a new surveillance operation for opioid-related morbidity and mortality, which is currently being used in 12 states. Dr. Houry highlighted this program because it provides information on opioid overdoses that don't result in death, allowing hotspots to be identified prior to a rise in deaths. She emphasized that the more granular information that CDC has access to, the more effectively they can tailor their response.

The data demonstrate a strong correlation between opioid prescription and opioid morbidity/mortality. Research shows that 75 percent of people who used heroin in the last year abused prescription opioids first and, in one state, one third of fentanyl deaths were linked to recent opioid prescription. In an acknowledgment of the importance of surveillance efforts to drive these initiatives, the Center has partnered with the Drug Enforcement Agency (DEA) to utilize some of their tracking tools. Other organizations that are working on reducing opioid-related harm are the National Center for Health Statistics, which is using literal text to supplement ICD-9 codes to specify opioids, and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), which is looking at a comprehensive prevention program that includes Hepatitis B and C.

While CDC is looking at the upstream causes of opioid abuse and related health issues, Dr. Houry asked for comments from ACD members about how these efforts can be improved. Dr. Houry acknowledges the importance of treatment, but doesn't want to miss the critical role that prevention plays. She reiterated Dr. Farley's earlier comment that, when CDC is successful, no one notices because they have prevented death and injury rather than treating it.

Dr. Farley shared that, in Philadelphia, there's an abundance of data on fatal overdoses; however, the relationship between prescribing practices and opioid use is less clear. To address this relationship, he's forced to search for oblique indicators, such as the DEA's data on bulk sales of opioids, which peaked in 2012 and has only decreased 10 percent since then. He also asked what portion of the recent federal funding allotment in the 21st Century Cures Act went to CDC. Dr. Houry noted that the funding allotment is intended to be used for treatment and recovery, so CDC is not receiving any money this year from that fund. She also mentioned that there will be a Vital Signs report in July focused on opioid prescribing practices. Finally, in response to Dr. Farley's comment, Dr. Houry noted that insurance companies have been increasingly active in targeting high prescribers, which has also resulted in a reduction.

Dr. Fielding shared that Kaiser Permanente in California came up with a good model in which they reduced their use by around 70 percent by giving feedback in real time to physicians. He opined that fentanyl will likely continue to be a problem and suggested looking at opioid abuse as a chronic disease. He also suggested using economic impact to make the anti-opioid argument.

Jonathan Mermin discussed midstream prevention efforts for those who make up the other quarter of opioid abusers, many of whom are injecting drugs. Syringe service programs are oftentimes the only access point with preventive services for this population other than the emergency room.

Dr. Goldman commented on the lack of discussion around making naloxone more widely available, arguing that it's still a part of public health and affects social cohesion. She commented that the current messaging misses more affluent high school-aged kids, for whom pill usage is very casual. Dr. Houry responded, in part, that naloxone is mentioned in the *CDC Guideline* and that the agency is currently evaluating the Substance Abuse and Mental Health Services Administration's (SAMHSA) naloxone program. As for messaging, Dr. Schuchat has kicked off a campaign based on "Tips from Smokers," aimed at informing the public in four states.

Dr. Elias asked about what relationships CDC has with medical licensing boards around this issue, because of the iatrogenic aspect of opioid abuse. He predicted that, if boards were to step up their surveillance in an information gathering and non-disciplinary posture, we might see a Hawthorne effect, causing people to be more careful simply as a result of being aware that they are under study. CDC is working with some states around the country already; for example, in West Virginia and Kentucky, prescribers are notified when a patient dies from an opioid-related cause. Coroners and medical examiners represent another untapped resource for opioid mortality information beyond toxicological testing. Dr. Wilma Wooten shared information about a pilot program exploring these issues with medical examiners in San Diego.

LaQuandra Nesbitt discussed the intersection of long term heroin users with fentanyl use in the District of Columbia. Demand for fentanyl is growing among these users. The District of Columbia's syndromic surveillance system provides data on non-fatal overdoses, while syringe exchange providers report back on neighborhood activity through peer-support networks. The District struggles with medication-assisted treatment options because neighborhoods protest the establishment of treatment centers. Consequently, the Department of Health relies on law enforcement to foster goodwill with the community in order to establish these medication-assisted therapy centers.

Jose Montero spoke from his history as a health officer in New Hampshire, which unfortunately leads the nation in overdose rates. He advocated for public health officials to act as neutral conveners on this issue. He also spoke to the need for more data and research on behavioral health issues to establish an evidence base that rivals that of chronic disease. He also advocated for increased data collection in these areas for tribal communities.

Dr. Fielding discussed treatment options, noting that medical therapy is not pursued in proportion to its effectiveness. He agreed that public health officials should act as conveners to that end. One of the impediments to medical therapies as treatment is the lack of reliable quality assurance measures. He suggested that CDC compose a list of questions that individuals can use to determine which program might be best for them.

Dr. Schuchat affirmed the importance of working on the opioid epidemic within the agency and encouraged ACD members to be in communication beyond the scope of committee meetings. In terms of national leadership, the Association of State and Territorial Health Officials (ASTHO) has stated that addiction is a priority for the organization this year. She also echoed Dr. Montero's comments on the role public health can and should play in the solution. CDC staff met with federal law enforcement agencies as well as the National Association of Medical Examiners to identify potential issues on which the organizations could collaborate regarding opioid abuse. The focus of the conversation has been around abuse in the U.S., but Dr. Schuchat informed the committee that Canadian health officials have contacted CDC about activating their emergency response resources for this issue.

Dr. Fleming shared some of his experience with this issue in Seattle-King County, and explained the importance of empowering local health officials to address opioid use/abuse. He argued for CDC to continue focusing on surveillance so that prevention program dollars can be spent in the most effective ways possible.

Discussion on Rural Health:
Von Nguyen, Acting Associate Director for Policy, gave the presentation. Disparities in rural health are a CDC-wide concern. The presentation will cover a high-level view of the issues affecting rural communities and will look at a subset of the larger group in greater detail, though not comprehensively. Dr. Nguyen noted that his presentation would not cover tribal and Indian health issues, which, while similar to rural health in their impact, are governed through a separate body within CDC.

The data show that rural areas experience higher age-adjusted death rates in the five leading causes of death (heart disease; cancer; unintentional injury; chronic lower respiratory disease; and stroke) than their urban counterparts. CDC uses the 2013 National Center for Health Statistics (NCHS) definition for urban and rural counties to determine the location of each. Rural areas encompass about 46 million Americans. Beyond having greater rates of mortality, rural communities also have a higher incidence of smoking, obesity, and physical inactivity during leisure time; have increased rates of poverty; and report having lower access to quality health care services. These health issues are driven by a lack of institutional resources, geographic isolation, low population density, and persistent poverty; it is more expensive to provide goods and services in more diffuse, less densely populated areas.

CDC began its MMWR series on rural health in early 2017. The articles endeavor to establish an evidence base for opportunities to improve public health programs in rural communities. The issues: analyze the leading causes of death and discuss potential opportunities to reduce excess deaths from the five leading causes; report on the health-related behaviors of community members; and examine mental,

behavioral, and developmental disorders in children. Dr. Nguyen highlighted some of the clinical ways in which the five leading causes of death could be reduced in rural communities.

Another method he noted is to focus on the social determinants of health. For example, CDC's High Obesity Program targeted counties where the adult obesity rate was at 40 percent or more. The program facilitated access to healthier foods and provided more opportunities to be physically active. CDC also supported worker's health programs like the National Healthy Worksite Program, which encouraged lifestyle management for blood pressure control and provided healthy food choices at worksites. Employers in this program in Buchanan County, Missouri saw obesity among employees decrease by 10 percent over the course of the program, and smoking rates decrease by 23 percent.

Rural communities also face challenges in terms of infectious disease. In 2015, Indiana declared an HIV-related public health emergency in a rural county after discovering a high incidence of the disease there stemming from injection drug use. At the county's request, CDC assisted in containing and treating the outbreak. CDC identified four critical actions to stop the outbreak: diagnosis and treatment of existing cases; implementation of a syringe service program; provision of medication-assisted treatment, and education. An analysis of national data revealed 220 counties in 26 states that are vulnerable to similar outbreaks, most of which were rural.

Local health departments play a large role in maintaining the health of rural communities, a trend that was highlighted in a 2016 study by the National Association of County and City Health Officials (NACCHO). The study showed that health departments in rural areas provide a significantly higher percentage of basic healthcare services than their urban counterparts. In support, CDC's Office of State, Tribal, Local and Territorial Support (OSTLTS) manages the Public Health Associates Program (PHAP), which provides workforce development to rural public health departments by assigning them recent college graduates to build capacity and fulfill organizational requirements.

CDC has partnered with a number of organizations on the topic of rural health; it has been researching new healthcare models and conducting listening sessions with both the Health Resources & Services Administration's Office of Rural Health Policy, and the Centers for Medicare and Medicaid Services. CDC has worked with the U.S. Department of Agriculture's (USDA) Food and Nutrition Services and the National Institute of Food and Agriculture to address obesity. OSTLTS has formed external partnerships with state health departments and is looking for upstream opportunities to affect social determinants of health.

After Dr. Nguyen's presentation, Dr. Bal shared some of his experiences transferring from a health department in a major metropolitan area to one on Kauai in Hawaii, reiterating just how different they are. Being 100 miles away from Honolulu and 2500 from California, he had to make do with the resources at hand. Dr. Bal also spoke to some of the silo-ing that goes on in rural health departments, noting that certain issues, such as behavioral health or drug abuse, go ignored because they are outside of an officer's expertise.

Dr. Goldman expressed excitement that the USDA was becoming interested in these issues because of their relationship with rural communities. She asked if CDC could look into ways to expand that relationship beyond obesity. The USDA should see itself as a part of public health, just as the Department of Housing and Urban Development (HUD) has begun to.

Dr. Elias summarized a presentation on the President's Emergency Plan for AIDS Relief (PEPFAR) program he had heard yesterday. He used that information to argue that CDC has the unique ability to provide data-based tools to drive programmatic efficiency and impact to larger organizations with larger budgets.

Dr. Fielding opined that state and local health departments have not always prioritized rural health issues to the extent that they should. On solution he suggested was inversely allocating resources relative to health. In addition to resources, rural communities may require a regional approach that may cut across the current city or county jurisdictions. Following up on these comments, Dr. Fleming agreed that it was up to CDC to develop the public health science about how to address this issue. He commented that it would be helpful to have more granular data as to what exactly leads to the increased rural mortality rates in the five leading causes. Lastly, he called for a comparison study of rural counties in order to better understand the differences among them.

Dr. Schuchat posed some additional questions for the committee to consider based on members' comments. She asked whether CDC should take the lead on providing technical assistance for telemedicine in rural communities. She also asked about who CDC's primary audience is based on questions around those resources that CDC traditionally relies upon in these communities.

Update on Laboratory Safety:

Steve Monroe, Associate Director for Laboratory Science and Safety (OADLSS), updated the committee on some of the recommendations he had received at the previous meeting. He began with an overview of the office's structure and its mission to make CDC labs the gold standard in scientific excellence and safety. To this end, last year, OADLSS conducted a risk assessment to ensure a rational approach to laboratory protocols, rather than defaulting to what always has been done. Of the 159 staff who submitted evaluations after this latest risk assessment training, 90 percent stated that they thought the objectives of the course were met. In addition to working with safety managers in each part of CDC that hosts a laboratory, Laboratory Science and Safety staff has been working towards obtaining biosafety credentials themselves. The inaugural class from the Laboratory Leadership Fellowship Program, conducted in collaboration with the Center for Surveillance, Epidemiology, and Laboratory Services (CSELS), will graduate this summer.

Dr. Monroe summarized the data from laboratory safety trainings conducted in 2016. Between 90 percent and 100 percent of participants for each training session thought that objectives were met, with similarly high numbers in two additional categories. The one outlier was related to disagreement about what qualifies as dual use research, which Dr. Monroe interpreted as not indicating any deficiency on the part of the training program. Through an HHS-wide program, Dr. Monroe and his team have been

able to make some of the training modules available to NIH, though he noted that feedback is stratified by location.

The office has launched a new safety campaign called "Be Incident Aware, Speak Up 4 Safety." One issue that has already been addressed by the office is improving the use of eyewear in biological laboratories. The office also updated the Radiation Safety Manual, though radio isotopes are essentially out of use across the Roybal Campus. It has also refined its laboratory staff awards to include both individual and group awards in both safety and quality. Lastly, in FY '16, the office implemented the Laboratory Safety Science and Innovation (LaSSI) intramural research fund to look at safety features like using pseudo-viruses instead of infectious viruses or utilizing automation to make labs safer.

Kenneth Berns asked if Dr. Monroe could comment on the issue CDC had with the air hoses in its biosafety level-4 laboratory. In the course of identifying infrastructure that needed to be replaced or repaired, CDC received correspondence stating that the breathing tubes that had been in use for the last 12 years were not suitable for use. They were able to suspend work and replace the breathing hoses as well as do a study in conjunction with the National Institute for Occupational Safety and Health (OSHA) on the quality of the old tubes. The results of the study revealed the old hoses to be better than the new hoses, so the new ones were replaced. The office derived a number of lessons about messaging in relation to these kinds of events to ensure that information is properly distributed both inside and outside of CDC.

Joseph Kanabrocki asked that Dr. Monroe devise a way of tracking the denominator for the staff in his training sessions to better identify trends. He praised Dr. Monroe's efforts in a number of areas, saying that it looked like he'd made many improvements since the last meeting. He asked where the latest edition of biosafety manual was. Dr. Monroe responded that shifting the course content to a curriculum basis should provide the standardization necessary to track denominators. As for the Biosafety in Microbiological and Biomedical Laboratories (BMBL), chapter authors have been identified and new chapters on biological safety in a clinical setting have been planned.

Dr. Schuchat informed the ACD that Dr. Monroe's successes are just a part of an ongoing effort throughout CDC to improve safety and to shift to a more proactive posture.

Health Disparities Subcommittee Update and Discussion:
Dr. Lynne Richardson, Chair of the Health Disparities Subcommittee, gave the report, summarizing the meeting from the day before. She noted that in May, the Office for Minority Health and Health Equity (OMHHE) and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) will publish an MMWR about the leading causes of death in African Americans. Dr. Richardson also highlighted the latest results from the Workforce Diversity Indicator Team. Because workforce diversity in the health care delivery system is a social determinant, the team aims to develop tools to effectively assess diversity in that arena. They've been making strong progress on this front, completing an environmental scan of data and an annotated bibliography. They've also begun the initial stakeholder

consultations. They'll soon be going into the field with their first test cases for physicians, with plans to develop similar tools for the health care and public health work forces.

Dr. Richardson reported on the Public Health Accreditation Board's (PHAB's) presentation to the subcommittee. The initial accreditation requirements published in 2011 were updated in 2014 to expand on concepts like health equity, among others. In 2017, the PHAB published its reaccreditation requirements for the initial set of accredited health departments. The idea behind reaccreditation was to foster continual development of public health agencies rather than impose compliance restrictions. The PHAB has placed health equity as a high priority throughout its member institutions, making it a requirement in annual reporting.

There was robust discussion within the subcommittee about a recommendation made jointly with the Social Determinants of Health (SDOH) Think Tank and the ACD, but Dr. Richardson explained that that would be covered later in the meeting.

Dr. Fielding asked if CDC has a database of interventions which have been proven to decrease the disparities which lead to health inequity. Dr. Leandris Liburd responded that, so far, CDC has produced two MMWRs, which discussed strategies to reduce health disparities that the agency has endorsed. CDC acknowledges, however, that more work needs to be done in this arena. Dr. Fielding argued that this effort should be done in a crosscutting way that includes an analysis of the literature in addition to the programs CDC has sponsored on its own. Dr. Richardson followed up, explaining that the subcommittee discussed the question of how best to demonstrate the impact of the health equity work already taking place.

Dr. Farley asked if CDC has any surveillance efforts around health disparities to judge whether progress is being made, recognizing the difficulty of such a project. Dr. Liburd replied that OMHHE published general health disparities reports in 2011 and 2012 that, despite demonstrating some of the work that has been done, were not as user-friendly as the office had hoped they would be. Dr. Schuchat reported that the Healthy People 2020 initiative demonstrated some encouraging data around improvements made to population health nationally. Dr. Fielding commented from his experience as the co-chair of the Healthy People 2020 effort, explaining that even though a high priority was placed on health disparities, the issue itself is so large and crosscutting that it's hard to give specific direction. He also expressed a desire to have a more scientific basis for the goals in the 2030 initiative.

Dr. Richardson commented that the whole effort around health disparities is hindered by the fact that there is no one body that collects data and develops indicators; rather, initiatives are piecemeal. Dr. Montero shared a couple of databases that had been brought about by previous directives from the ACD to establish repositories for this kind of information. Additionally, periodic reports like the Preventive Health Status Reports provide updates on developments in the field. Dr. Wooten asked that a summary report consolidating the work that has been done so far and outlining what there is to do next be produced for next year. Dr. Goldman asked that the environmental piece of the health disparities

equation not be forgotten. She also informed the ACD that students at her school have been galvanized by this issue, suggesting that they might be a resource to consider for a health equity project.

State, Tribal, Local, and Territorial Subcommittee Update and Discussion:
Dr. Wooten gave the report. The STLTS Committee provides ongoing advice and recommendations to the ACD about public health policies and practices at a variety of tiers. The subcommittee graduated from its workgroup status in June 2013. Since then, 30 of its recommendations have been adopted by ACD. These recommendations grew out the STLT sub-groups named think tanks. There are three think tanks: public health surveillance, public health finance, and social determinants of health. Dr. Wooten noted that block grants are a potential topic for the Finance Think Tank to address.

STLT is presenting two recommendations today. The first comes out of the Public Health Surveillance Think Tank. The other is the joint recommendation with the Health Disparities Subgroup that Dr. Richardson mentioned earlier. For the first recommendation, given the significant roe that data collection and analysis play in helping CDC fulfill its mission, the Public Health Think Tank proposes that CDC develop a cost analysis for modernizing and maintaining the national public health information infrastructure. This analysis could provide the basis for a ten year plan to develop, govern, and maintain the infrastructure.

Dr. Richardson then provided the background for the second (joint) recommendation. At their October meetings, the SDOH Think Tank and the Health Disparities Subcommittee, given their alignment, decided to draft together a set of recommendations to the incoming administration as to what it should focus on. While no one anticipated the current circumstances, the subcommittee reaffirmed the importance of delivering these recommendations to the incoming director. The recommendation is that the ACD should advise the new administration to preserve and expand upon CDC's current health equity and structural determinants of health work.

Dr. Fleming opened up discussion on the first recommendation. Dr. Farley expressed confusion at the scope of this recommendation. Dr. Wooten explained that the idea is to establish a baseline for the costs to bring everyone to baseline level of competence when it comes to sharing information. Michael Iademarco commented that the scope was intended to be broad. From the practitioner side, Dr. Nesbitt commented that current information systems have a healthcare delivery bias that public health has to then retrofit for use in its domain. The issue then becomes that when practitioners attempt to do electronic case reporting (ECR) or electronic laboratory reporting (ELR), they don't know what the cost of that is.

Dr. Goldman stated that the second sentence needs to be wordsmithed to reconcile the broad scope implied by the first sentence and the narrow scope of projects like the Digital Bridge. Dr. Farley added that if the intent is to only include surveillance based off of medical records, which is narrower than all forms of surveillance, then clarification needs to be added. If the intent is to include all forms of surveillance, he agrees that the second sentence doesn't fit with the first. Dr. Bal made a general comment that the subcommittee and the think tank could use a better balance of local health officers

versus state health officers. As for the language piece, Dr. Bal expressed agreement with Dr. Goldman and Dr. Farley. As for appropriate scope, Dr. Fielding commented that public health wants something that captures both the intervention efforts and the outcomes. Dr. Wooten noted that instead of invoking projects by name, members would prefer to simply describe what a project does. Given the number of suggestions, no vote was taken to adopt the first recommendation on public health surveillance, rather, Dr. Wooten agreed to return the recommendation to the subcommittee think tank to reword it, in order to better reflect the opinions of Committee members.

Dr. Bal started off the round of commentary on the second recommendation. He spoke about the importance of health equity work given the socioeconomic trends of the nation over the last half century. In light of this, he emphatically argued for the language to be punched up and for "advised" to be replaced with a term like "urged" or "strongly recommended." Dr. Berns expressed some confusion about whether higher mortality rates among whites were reflected in the scope of this recommendation. Dr. Nesbitt raised the tendency to focus too much on responding to year to year changes in statistics instead of looking at longer term trends. While there may be a new negative delta among the white population in the U.S., their overall health remains better than communities of color. She further clarified that the purpose of health equity is to ensure equal access to opportunities for health regardless of race, place, gender, et cetera.

Dr. Fleming called a vote on the second (joint) recommendation from SDOH Think Tank (and the Health Disparities Subcommittee). The ACD voted unanimously in favor.

Public Health – Health Care Collaboration Workgroup Update and Discussion:
Dr. Nesbitt gave the report. The workgroup's transition process to becoming a full subcommittee has begun. The workgroup looks to better understand what partnerships already exist and how current successes can be scaled. The workgroup intends to make feasible, CDC-centric recommendations, which improve population health and have an identifiable outcome. Dr. Nesbitt gave an overview of the workgroup's membership and their affiliations.

The workgroup's discussion questions in its previous meeting revolved around optimizing investments in prevention, strengthening and aligning hospital community benefits with the community health needs assessment process, and institutionalizing models and partnerships. Out of those questions grew a number of themes. The group expressed enthusiasm for the 6|18 Initiative and the Office of the Associate Director for Policy's (OADP) efforts. The group identified the kind of public health/health care infrastructure that enabled responses like the one in Scott County, Indiana as an essential foundation for future collaboration. How does CDC identify and expand upon that existing infrastructure? The next theme was using science to drive action. Because of the level of respect CDC commands, it can act as an effective neutral convener in addressing these questions. The other part of this project is creating a value proposition that can be sold to the different players in the arenas of public health and health care. Dr. Nesbitt stressed that this must be done in a bidirectional fashion and not just be public health coming to health care systems to tell them what to do.

Moving forward, a webinar is scheduled for July 19th, with the next in-person meeting occurring sometime in September 2017. The group will continue with the process of becoming a subcommittee. A lot of big ideas came out of the last in-person meeting and the group plans to work with OADP around some time-bound recommendations to present in the fall.

Dr. Richardson commented that, in terms of leveraging new payment models, there should be some degree of risk-taking involved when it comes to improving public health. She shared some personal experiences to highlight the positive outcomes stemming from a willingness to take risk. As an emergency physician, the treatment options she has can vary widely depending on who the payer is.

Dr. Wooten suggested that Dr. Nesbitt's group look at OSTLTS and the STLTS Subcommittee for examples of partnerships with non-health care organizations whose models can still be applied in the health care system realm. Laura Seeff commented that part of the issue here is normalizing cross-sectoral partnerships.

Global Workgroup Update and Discussion:

Dr. Elias gave the report. The Global Workgroup has also begun the transition process to becoming a full subcommittee. During the workgroup's meeting, Rebecca Martin from the Center for Global Health gave an overview of her organization. The workgroup also heard two presentations on Zika. The final presentation was on the PEPFAR. Dr. Elias elaborated that the common themes throughout all of these presentations were communication, financial stability, and the role of CDC in complex global partnerships. As Dr. Schuchat noted earlier, CDC's role in providing assistance on a global scale is underappreciated at home. People tend to ask why CDC is working in global health, until there is a crisis. Then those same people ask why CDC isn't doing more in global health. The lack of a sustained agenda or sustained financial commitment to global health drives this vacillation.

Reliance on supplementary funding means that CDC's global health work often faces cliff after cliff. Dr. Elias used polio as an example, pointing out that if the world is declared polio-free in 2020, it will be hard to sustain appropriations to treat polio after that fact. Yet, there's an imbalance where much of the current global immunization regime relies upon funds drawn from polio appropriations because of the synergies between immunization for polio and immunization for other diseases. The question then becomes how stakeholders should go about addressing these issues.

As a final note, Dr. Elias spoke about the difficulties in Zika classification of countries and what impact different classifications might have on those countries. When you look at the four categories of Zika classification (1. Area with new introduction or re-introduction with ongoing transmission; 2. Area either with evidence of virus circulation before 2015 or area with ongoing transmission that is no longer in the new or re-introduction phase, but where there is no evidence of interruption; 3. Area with interrupted transmission and with potential for future transmission; 4: Area with established competent vector but no known documented past or current transmission), for example, the U.S. and its territories have areas that fall under each, demonstrating the importance of a more granular view.

Given these uncertainties, CDC needs to develop a clear and succinct message about its work in global health, one that demonstrates its value more clearly. Historically, the role that CDC's global health operations have play in protecting American health hasn't been clear enough. With that, Dr. Fleming opened the floor for questions.

Carmen Villar added to Dr. Elias' comments on polio immunization. Seventy five percent of the Global Immunization Division's budget is polio-related. This problems puts into focus the need to figure out an alternate method of funding global immunization besides jumping from supplementary funding stream to supplementary funding stream. She also agreed that global health would benefit from a clear and precise message about its value. Dr. Fleming suggested that, in light of the public health – health care collaboration discussion, global health may have some models that can positively affect disparity reduction.

Suggestions for Future ACD Agenda Items:
Dr. Fleming offered that one of the goals for the next meeting should be to establish some degree of interpersonal connection to the new director. Dr. Goldman suggested that there be some element that acquaints them with the landscape and hierarchies of the working groups and subcommittees. She suggested that the various chairs think about how they want to present themselves. Dr. Farley agreed, saying it would be nice to get a deeper picture of the subcommittees and working groups beyond the brief overviews given today. Dr. Berns suggested that the ACD consider bridging between the subcommittees and workgroups to discuss how the U.S. compares to the rest of the world in terms of outcomes. Dr. Nesbitt echoed Dr. Farley's comments, saying that there should perhaps be no CDC presentations to allow for workgroup and subcommittee presentations to be more detailed.

Public Comment:
There were no public comments.

Closing Remarks and Adjournment:
Dr. Fleming praised the meeting as being perhaps one of the best this group has had yet. He said, for his part, he felt like the group was able to strike the balance between contributing to CDC while sharing important information. Dr. Schuchat thanked CDC staff for enabling the meeting and thanked Sarah Wiley for serving as DFO. She also said that she heard the comments throughout all of the day's presentations about needing to streamline communications and maintain a united front when it came to demonstrating the agency's value. Dr. Fleming adjourned the meeting at 1:40 pm.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 20, 2017 meeting of the Advisory Committee to the Director, CDC are accurate and complete.

Date

David Fleming, MD
Chair, Advisory Committee to the Director, CDC